SECTION X - GENERAL INFORMATION - EDS

A. Correspondence Forms Instructions

Type of Information Requested	Time Frame for Inquiry	Mailing Address
Inquiry	6 weeks after billing	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Communications Unit
Adjustment	Immediately	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Adjustments Unit
Refund	Immediately	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Cash/Finance Unit

Type of Information Requested	Necessary Information
Inquiry	1. Completed Inquiry Form 2. Remittance Advice or Medicare EOMB, when applicable 3. Other supportive documentation, when needed, such as a photocopy of the Medicaid claim when a claim has not appeared on an R/A within a reasonable amount of time

Type of Information Requested	Necessary Information
Adjustment	1. Completed Adjustment Form 2. Photocopy of the claim in question 3. Photocopy of the applicable portion of the R/A in question
Refund	1. Refund Check 2. Photocopy of the applicable portion of the R/A in question 3. Reason for refund

B. Telephoned Inquiry Information

What is Needed?

- Provider number
- Patient's Medicaid ID number
- Date of service
- Billed amount
- Your name and telephone number

When to Call?

- When claim is not showing on paid, pending or denied sections of the R/A within 6 weeks
- When the status of claims are needed and they do not exceed five in number

Where to Call?

- Toll-free number 1-800-333-2188[~~372-2921~~] (within Kentucky)
- Local (502) 227-2525

C. Filing Limitations

New Claims	-	12 months from date of service
Medicare/Medicaid Crossover Claims	-	12 months from date of service NOTE: If the claim is a Medicare crossover claim and is received by EDS more than 12 months from date of service, but less than 6 months from the Medicare adjudication date, EDS considers the claim to be within the filing limitations and will proceed with claims processing.
Third-Party Liability Claims	-	12 months from date of service NOTE: If the other insurance company has not responded within 120 days of date of service, submit the claim to EDS indicating "NO RESPONSE" from the other insurance company.
Adjustments	-	12 months from date the paid claim appeared on the R/A

D. Provider Inquiry Form

The Provider Inquiry form should be used for inquiries to EDS regarding paid or denied claims, billing concerns, and claim status. (If requesting more than one claim status, a Provider Inquiry form should be completed for each status request.) The Provider Inquiry Form should be completed in its entirety and mailed to the following address:

EDS
P.O. Box 2009
Frankfort, KY 40602

Supplies of the Provider Inquiry form may be obtained by writing to the above address or contacting EDS Provider Relations Unit at 1-(800)-333-2188[~~372-2921~~] or 1-(502)-227-2525.

Please remit BOTH[~~both~~] copies of the Provider Inquiry form to EDS. Any additional documentation that would help clarify your inquiry should be attached. EDS will enter their response on the form and the yellow copy will be returned to the provider.

It is NOT[~~not~~] necessary to complete a Provider Inquiry form when resubmitting a denied claim.

Provider Inquiry forms may NOT[~~not~~] be used in lieu of KMAP claim forms, Adjustment forms, or any other document required by KMAP.

In certain cases it may be necessary to return the inquiry form to the provider for additional information if the inquiry is illegible or unclear.

Instructions for completing the Provider Inquiry form are found on the next page.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

AMBULATORY SURGICAL CENTER SERVICES[~~Ambulatory Surgical Center Services~~]

Medicaid covers medically necessary services performed in ambulatory surgical centers.

BIRTHING CENTER SERVICES[~~Birthing Center Services~~]

Covered birthing center services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two follow-up postnatal visits within 4-6 weeks of the delivery date.

DENTAL SERVICES[~~Dental Services~~]

Coverage is limited but includes X-rays, fillings, simple extractions, and emergency treatment for pain, infection and hemorrhage. Preventive dental care is stressed for individuals under age 21.

DURABLE MEDICAL EQUIPMENT

Certain medically necessary items of durable medical equipment, orthotic and prosthetic devices may be covered when ordered by a physician and provided by suppliers of durable medical equipment, orthotic and prosthetics. Most items require prior authorization.

FAMILY PLANNING SERVICES[~~Family Planning Services~~]

Comprehensive family planning services are available to all eligible Title XIX recipients of childbearing age and those minors who can be considered sexually active. These services are offered through participating agencies such as local county health departments and independent agencies, i.e., Planned Parenthood Centers. Services are also available through private physicians.

A complete physical examination, counseling, contraceptive education and educational materials, as well as the prescribing of the appropriate contraceptive method, are available through the Family Planning Services element of the KMAP. Follow-up visits and emergency treatments are also provided.

HEARING SERVICES[~~Hearing Services~~]

Hearing evaluations and single hearing aids, when indicated, are paid for by the program for eligible recipients, to the age of 21. Follow-up visits, as well as check-up visits, are covered through the hearing services element. Certain hearing aid repairs are also paid through the program.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

HOME HEALTH SERVICES[~~Home Health Services~~]

Skilled nursing services, physical therapy, speech therapy, occupational therapy and aide services are covered when necessary to help the patient remain at home. Medical social worker services are covered when provided as part of these services. Home Health coverage also includes disposable medical supplies.[~~;~~] [~~and durable medical equipment, appliances and certain prosthetic devices on a preauthorized basis.~~] Coverage for home health services is not limited by age.

HOSPITAL SERVICES[~~Hospital Services~~]

INPATIENT SERVICES[~~Inpatient Services~~]

KMAP benefits include reimbursement for admissions to acute care hospitals for the management of an acute illness, an acute phase or complications of a chronic illness, injury, impairment, necessary diagnostic procedures, maternity care, and acute psychiatric care. All non-emergency hospital admissions must be preauthorized by a Peer Review Organization. Certain surgical procedures are not covered on an inpatient basis, except when a life-threatening situation exists, there is another primary purpose for admission, or the physician certifies a medical necessity requiring admission to the hospital. Elective and cosmetic procedures are outside the scope of program benefits unless medically necessary or indicated. Reimbursement is limited to a maximum of fourteen (14) days per admission.

OUTPATIENT SERVICES[~~Outpatient Services~~]

Benefits of this program element include diagnostic, therapeutic, surgical and radiological services as ordered by a physician; clinic visits, selected biological and blood constituents, emergency room services in emergency situations as determined by a physician; and services of hospital-based emergency room physicians.

There are no limitations on the number of hospital outpatient visits or services available to program recipients.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

LABORATORY SERVICES[~~Laboratory Services~~]

Coverage of laboratory procedures for Kentucky Medical Assistance Program (KMAP) participating independent laboratories includes procedures for which the laboratory is certified under Medicare.[~~The following laboratory tests covered when ordered by a physician and done in a laboratory certified by the Department of Health and Human Services:~~]

[~~Cultures (Screening)~~
~~Blood Culture (definitive)~~
~~Stool (Ova and parasites)~~
~~Smears for Bacteria, Stained~~
~~Bilirubin~~
~~Bleeding Time~~
~~Red Blood Count~~
~~Hemoglobin~~
~~White Blood Count~~
~~Differential~~
~~Complete Blood Count~~
~~Cholesterol~~
~~Clotting Time~~
~~Hematocrit~~
~~RA Test (Latex Agglutinations)~~
~~Acid Phosphatase~~
~~Alkaline Phosphatase~~
~~Potassium~~
~~Prothrombin Time~~
~~Sedimentation Rate~~
~~Uric Acid~~
~~Stool (Occult Blood)~~
~~Pap Smear~~
~~Urine Analysis~~
~~Urine Culture~~
~~Sensitivity Testing~~]

[~~Pregnancy Test~~
~~CPK/Creatine~~
~~Thyroid Profile~~
~~T3~~
~~T4~~
~~Glucose Tolerance~~
~~Electrolytes~~
~~Dilantin/Phenobarbital/Drug Abuse Screen~~
~~Arthritis Profile~~
~~VDRL~~
~~Glucose (Blood)~~
~~SGOT or SGPT (Serum Transaminase)~~
~~Blood Typing~~
~~Blood Urea Nitrogen~~
~~Sodium~~
~~Any 3 or More Automated Tests~~
~~Rubella~~
~~Therapeutic Drug Monitoring~~
~~Lithium~~
~~Theophylline~~
~~Digoxin~~
~~Digitoxn~~]

LONG TERM CARE FACILITY SERVICES[~~Long Term Care Facility Services~~]

SKILLED NURSING FACILITY SERVICES[~~Skilled Nursing Facility Services~~]

The KMAP can make payment to skilled nursing facilities for:

A. Services provided to Medicaid recipients who require twenty-four (24) skilled nursing care and/or skilled services which as a practical matter can only be provided on an inpatient basis.*

B. Services provided to recipients who are also medically eligible for Medicare benefits in the skilled nursing facility.

-Coinsurance from the 21st through the 100th day of this Medicare benefit period.
-Full cost for the full length of stay after the 100th day if 24-hour skilled nursing care is still required.*

*Need for skilled nursing care must be certified by a Peer Review Organization (PRO).

INTERMEDIATE CARE FACILITY SERVICES[~~Intermediate Care Facility Services~~]

The KMAP can make payment to intermediate care facilities for:

A. Services provided to recipients who require intermittent skilled nursing care and continuous personal care supervision.*

B. Services provided to Medicaid recipients who are mentally retarded or developmentally disabled prior to age 22, who because of their mental and physical condition require care and services which are not provided by community resources.*[~~**~~]

*Need for the intermediate level of care and the ICF/MR/DD level of care must be certified by a PRO.[~~*Need for the intermediate level of care must be certified by a PRO. **Need for the ICF/MR/DD level of care must be certified by the Department for Medicaid Services.~~]

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDCAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

MENTAL HOSPITAL SERVICES[~~Mental Hospital Services~~]

Inpatient psychiatric services are provided to Medicaid recipients under the age of 21 and age 65 or older in a psychiatric hospital. There is no limit on length of stay; however, the need for inpatient psychiatric hospital services must be verified through the utilization control mechanism.

COMMUNITY MENTAL HEALTH CENTER SERVICES[~~Community Mental Health Center Services~~]

Community mental health-mental retardation centers serve recipients of all ages in the community setting. From the center a patient may receive treatment through:

Outpatient Services
Psychosocial Rehabilitation[~~Partial Hospitalization~~]
Emergency Services
Inpatient Services
Personal Care Home Visits

Eligible Medicaid recipients needing psychiatric treatment may receive services from the community mental health center and possibly avoid hospitalization. There are fourteen (14) major centers, with many satellite centers available. Kentucky Medical Assistance Program reimburses private practicing psychiatrists for psychiatric services through the physician program.

NURSE ANESTHETIST SERVICES[~~Nurse Anesthetist Services~~]

Anesthesia services performed by a participating Advanced Registered Nurse Practitioner - Nurse Anesthetist are covered by the KMAP.

NURSE MIDWIFE SERVICES[~~Nurse Midwife Services~~]

Medicaid coverage is available for services performed by a participating Advanced Registered Nurse Practitioner - Nurse Midwife. Covered services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two follow-up post partum visits within 4 to 6 weeks of the delivery date.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDCAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

PHARMACY SERVICES[~~Pharmacy Services~~]

Legend and non-legend drugs from the approved Medical Assistance Drug List when required in the treatment of chronic and acute illnesses are covered by the KMAP. The Department is advised regarding the outpatient drug coverage by a formulary subcommittee composed of persons from the medical and pharmacy professions. A Drug List is available to individual pharmacists and physicians upon request and routinely sent to participating pharmacies and long-term care facilities. The Drug List is distributed quarterly with monthly updates.

In addition, certain other drugs which may enable a patient to be treated on an outpatient basis and avoid institutionalization are covered for payment through the Drug Preauthorization Program.

PHYSICIAN SERVICES[~~Physician Services~~]

Covered services include:

Office visits, medically indicated surgeries, elective sterilizations*, deliveries, chemotherapy, radiology services, emergency room care, anesthesiology services, hysterectomy procedures*, consultations, second opinions prior to surgery, assistant surgeon services, oral surgeon services, psychiatric services.

*Appropriate consent forms must be completed prior to coverage of these procedures.

Non-covered services include:

Injections, [~~immunizations~~,] supplies, drugs (except anti-neoplastic drugs), cosmetic procedures, package obstetrical care, [~~contact lenses~~,] IUDs, diaphragms, prosthetics, various administrative services, miscellaneous studies, post mortem examinations, surgery not medically necessary or indicated.

Limited coverage:

One comprehensive office visit per twelve (12) month period, per patient, per physician.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDCAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

PHYSICIAN SERVICES (Continued)

The following laboratory procedures are covered when performed in the office by an M.D. or osteopath.

Ova and Parasites (feces)
Smear for Bacteria, stained
Throat Cultures (Screening)
Red Blood Count
Hemoglobin
White Blood Count
Differential Count
Bleeding Time
Electrolytes
Glucose Tolerance
Skin Tests for:
  Histoplasmosis
  Tuberculosis
  Coccidioidomycosis
  Mumps
  Brucella
Complete Blood Count
Hematocrit
Prothrombin Time
Sedimentation Rate
Glucose (Blood)
Blood Urea Nitrogen (BUN)
Uric Acid
Thyroid Profile
Platelet count
Urine Analysis
Creatinine

Bone Marrow spear and/or cell block; aspiration only
Smear; interpretation only
Aspiration; staining and interpretation
Aspiration and staining only
Bone Marrow needle biopsy
Staining and interpretation
Interpretation only
Fine needle aspiration with or without preparation of smear; superficial tissue
Deep tissue with radiological guidance
Evaluation of fine needle aspirate with or without preparation of smears
Duodenal intubation and aspiration: single specimen
Multiple specimens
Gastric intubation and aspiration: diagnostic
Nasal smears for eospinophils
Sputum, obtaining specimen, aerosol induced technique

PODIATRY SERVICES

Selected services provided by licensed podiatrists are covered by the Kentucky Medical Assistance Program. Routine foot care is covered only for certain medical conditions where such care requires professional supervision.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDCAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

PRIMARY CARE SERVICES[~~Primary Care Services~~]

A primary care center is a comprehensive ambulatory health care facility which emphasizes preventive and maintenance health care. Covered outpatient services provided by licensed, participating primary care centers include medical services rendered by advanced registered nurse practitioners as well as physician, dental and optometric services, family planning, EPSDT, laboratory and radiology procedures, pharmacy, nutritional counseling, social services and health education. Any limitations applicable to individual program benefits are generally applicable when the services are provided by a primary care center.

RENAL DIALYSIS CENTER SERVICES[~~Renal Dialysis Center Services~~]

Renal service benefits include renal dialysis, certain supplies and home equipment.

RURAL HEALTH CLINIC SERVICES[~~Rural Health Clinic Services~~]

Rural health clinics are ambulatory health care facilities located in rural, medically underserved areas. The program emphasizes preventive and maintenance health care for people of all ages. The clinics, though physician directed, must also be staffed by Advanced Registered Nurse Practitioners. The concept of rural health clinics is the utilization of mid-level practitioners to provide quality health care in areas where there are few physicians. Covered services include basic diagnostic and therapeutic services, basic laboratory services, emergency services, services provided through agreement or arrangements, visiting nurse services and other ambulatory services.

SCREENING SERVICES[~~Screening Services~~]

Through the screening service element, eligible recipients, age 0-thru birth month of 21st birthday, may receive the following tests and procedures as appropriate for age and health history when provided by participating providers:

- Medical History
- Physical Assessment
- Growth and Developmental Assessment
- Screening for Urinary Problems
- Screening for Hearing and Vision Problems
- Tuberculin Skin Test
- Dental Screening
- Screening for Veneral Disease, As Indicated
- Assessment and/or Updating of Immunizations

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDCAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

TRANSPORTATION SERVICES[~~Transportation Services~~]

Medicaid may cover transportation to and from Title XIX-covered medical services by ambulance or other approved vehicle if the patient's condition requires special transportation. Also covered is preauthorized non-emergency medical transportation to physicians and other non-emergency, Medicaid-covered medical services. Travel to pharmacies is not covered.

VISION SERVICES[~~Vision Services~~]

Examinations and certain diagnostic procedures performed by ophthalmologists and optometrists are covered for recipients of all ages. Professional dispensing services, lenses, frames and repairs are covered for persons under age 21.

SPECIAL PROGRAMS[~~SPECIAL PROGRAMS~~]

KENPAC: The Kentucky Patient Access and Care System, or KenPAC, is a special program which links the recipient with a primary physician or clinic for many Medicaid-covered services. Only recipients who receive assistance based on Aid to Families with Dependent Children (AFDC) or AFDC-related Medical Assistance Only are covered under KenPAC. The recipient may choose the physician or clinic. It is especially important for the KenPAC recipient to present his/her Medical Assistance Identification Card each time a service is received.

AIS/MR: The Alternative Intermediate Services/Mental Retardation (AIS/MR) home- and community-based services project provides coverage for an array of community based services that is an alternative to receiving the services in an intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR/DD). Community mental health centers arrange for and provide these services.

HCB: A home- and community-based services project[~~currently in the Bluegrass Area Development District~~] provides Medicaid coverage for a broad array of home- and community-based services for elderly and disabled recipients. These services are available to recipients who would otherwise require the services in a skilled nursing facility (SNF) or intermediate care facility (ICF). The services were[~~are expected to be available~~] statewide July 1, 1987. These services are arranged for and provided by home health agencies.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDCAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

HOSPICE:[~~HOSPICE~~]

Medicaid benefits include reimbursement for hospice care for Medicaid clients who meet the eligibility criteria for hospice care. Hospice care provides to the terminally ill relief of pain and symptoms. Supportive services and assistance are also provided to the patient and his/her family in adjustment to the patient's illness and death. A Medicaid client who elects to receive hospice care waives all rights to certain Medicaid services which are included in the hospice care scope of benefits.

TARGETED CASE MANAGEMENT SERVICES:

Comprehensive case management services are provided to handicapped or impaired Medicaid-eligible children under age 21 who also meet the eligibility criteria of the Commission for Handicapped Children, the State's Title V Crippled Children's Agency. Recipients of all ages who have hemophilia may also qualify.

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

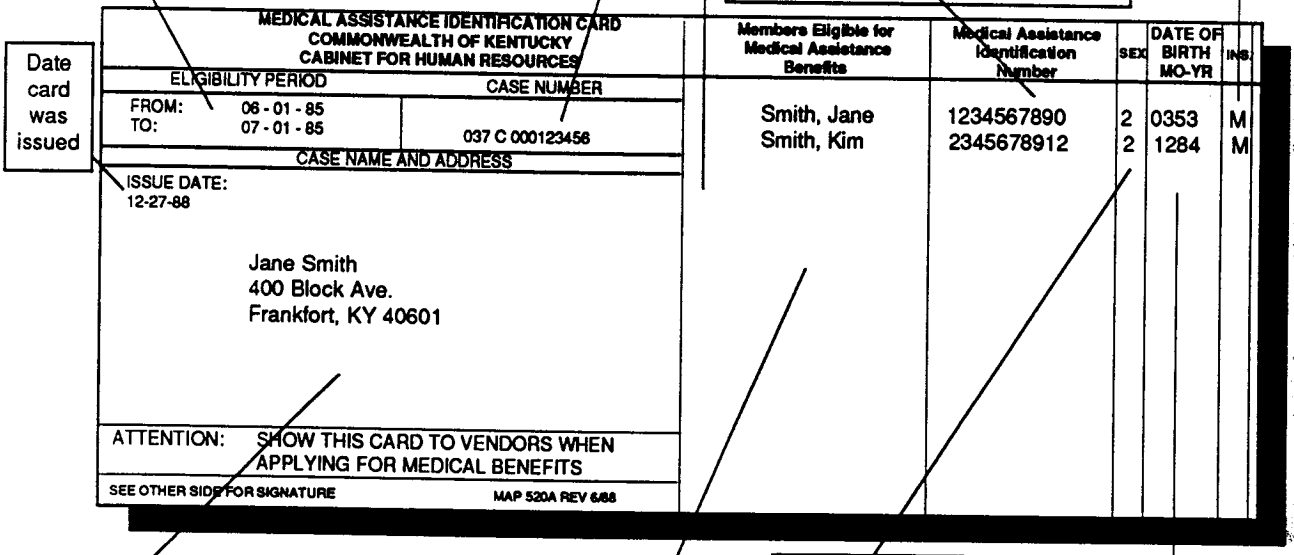
(FRONT OF CARD)

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Medical Insurance Code indicates type of insurance coverage.

Eligibility period is the month, day and year of KMAP eligibility represented by this card. " From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.



Date card was issued

Case name and address show to whom the card is mailed. The name in this block may be that of a relative or other interested party and may not be an eligible member.

For K.M.A.P. Statistical Purposes

Name of members eligible for Medical Assistance benefits. Only those persons whose names are in this block are eligible for K.M.A.P. benefits.

Date of Birth shows month and year of birth of each member . Refer to this block when providing services limited to age.

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

(BACK OF CARD)

Information to Providers. Insurance Identification codes indicate type of insurance coverage as shown on the front of the card in "Ins." block.

This card certifies that the person(s) listed hereon is /are eligible during the period indicated on the reverse side for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to: Cabinet for Human Resources
Department for Social Insurance
Division of Medical Assistance
Frankfort, KY 40621

Insurance Identification

A Part A Medicare Only	G Champus
B Part B Medicare Only	H Health Maintenance Organization
C Both Parts A & B Medicare	J Other and or Unknown
D Blue Cross Blue Shield	L Absent Parent's Insurance
E Blue Cross Blue Shield Major Medical	M None
	N United Mine Workers
F Private Medical Insurance	P Black Lung

RECIPIENT OF SERVICES

1. This card may be used to obtain certain services from participating hospitals, durg stores, physicians, dentists, nursing homes, intermediate care facilities. independent laboratories, home health agencies, community mental health centers, and participating providers of hearing, vision, ambulance, non-emergency transportation, screening, and family planning services.
2. Show this card whenever you receive medical care or have prescriptions filled, to the person who provides these services to you.
3. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below, and destroy your old card. Remember that it is against the law for anyone to use this card except the persons listed on the front of this card.
4. If you have questions, contact your eligibility worker at the county office.
5. Recipient temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance.

_____
Signature

RECIPIENT OF SERVICES: You are hereby notified that under State Law KRS 205 624 your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Federal law provides for a $10,000 fine or imprisonment for a year or both for anyone who willfully gives false information in applying for medical assistance fails to report changes relating to eligibility or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

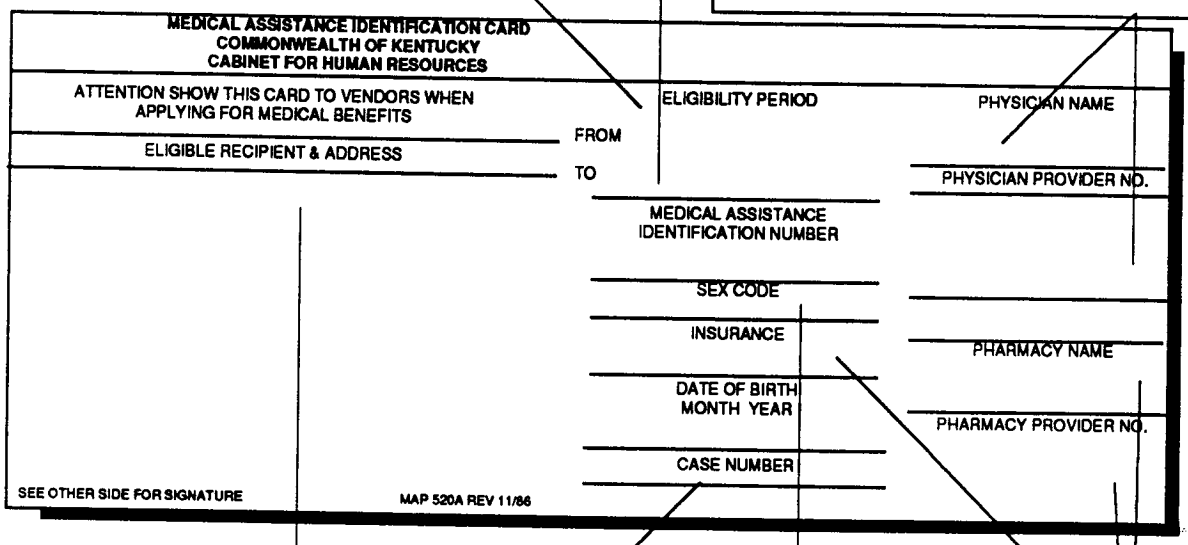
KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(FRONT OF CARD)

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

Eligibility period shows dates of eligibility represented by this card. " From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Name and provider number of Lock-In physician. KMAP payments will be limited to this physician (with the exception of emergency services and physician referral unless otherwise authorized by the KMAP.



Name and address of member eligible for Medical Assistance benefits. All eligible individuals in the Lock-In Program will receive a separate card.

Currently Left Blank

Insurance Code

Department for Social Insurance case number. This is **NOT** the Medical Assistance Identification Number.

Name, address, and provider number of Lock-In pharmacy. Payment for pharmacy services is limited to this pharmacy, except in cases of emergency. In case of emergency, payment for covered services can be made to any participating pharmacy, provided notification and justification of the service is given to the lock-in program.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX II-B

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(BACK OF CARD)

Information to Providers, including procedures for emergency treatment, and identification of insurance as shown on the front of the card in "Ins." block.

ATTENTION

This card certifies that the person listed on the front of this card is eligible during the period indicated for current benefits of the Kentucky Medical Assistance Program. Payment for physician and pharmacy services is limited to the physician and pharmacy appearing on the front of this card.

In the event of an emergency, payment can be made to any participating physician or participating pharmacy rendering service to this person if it is a covered service. The patient is not restricted with regard to other services; however, payment can only be made within the scope of Program benefits. Recipient temporarily out of state may receive emergency medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance. Questions regarding scope of services should be directed to the Lock-In coordinator by calling 502-564-5560.

You are hereby notified that under State Law KRS 205 624 your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Insurance Identification

A Part A Medicare Only
B Part B Medicare Only
C Both Parts A & B Medicare
D Blue Cross Blue Shield
E Blue Cross Blue Shield Major Medical
F Private Medical Insurance
G Champus
H Health Maintenance Organization
J Other and or Unknown
L Absent Parent's Insurance
M None
N United Mine Workers
P Black Lung

I have read the above information and agree with the procedures as outlined and explained to me

Signature of Recipient or Representative _____ Date _____

RECIPIENT OF SERVICES

Federal law provides for a $10,000 fine or imprisonment for a year or both for anyone who willfully gives false information in applying for medical assistance fails to report changes relating to eligibility or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

KENTUCKY PATIENT ACCESS AND CARE (KENPAC) SYSTEM CARD

(FRONT OF CARD)

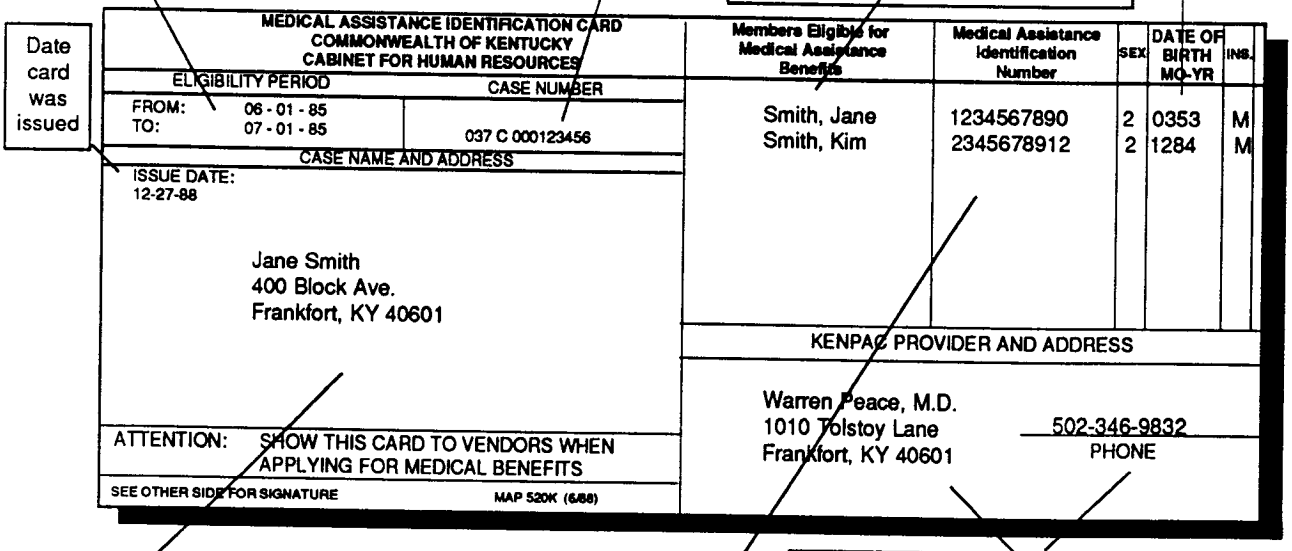
Eligibility period shows dates of eligibility represented by this card. " From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day. KenPAC services provided during this eligibility period must be authorized by the Primary Care physician listed on this card.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

Names of members eligible for KMAP. Persons whose names are in this block have thePrimary Care provider listed on this card.

Date card was issued


MEDICAL ASSISTANCE IDENTIFICATION CARD
COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES

ELIGIBILITY PERIOD
FROM: 06 - 01 - 85
TO: 07 - 01 - 85

CASE NUMBER
037 C 000123456

CASE NAME AND ADDRESS

ISSUE DATE:
12-27-88

Jane Smith
400 Block Ave.
Frankfort, KY 40601

ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS

SEE OTHER SIDE FOR SIGNATURE

MAP 520K (6/88)

Members Eligible for Medical Assistance Benefits	Medical Assistance Identification Number	SEX	DATE OF BIRTH MO-YR	INS.
Smith, Jane	1234567890	2	0353	M
Smith, Kim	2345678912	2	1284	M

KENPAC PROVIDER AND ADDRESS

Warren Peace, M.D.
1010 Tolstoy Lane
Frankfort, KY 40601

502-346-9832
PHONE

Case name and address show to whom the card is mailed. This person may be that of a relative or other interested party and may not be an eligible member.

Name, address and phone number of the Primary Care Physician.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX II-C

KENTUCKY PATIENT ACCESS AND CARE (KENPAC) SYSTEM CARD

(BACK OF CARD)

Information to Providers. including Insurance Identification codes which indicate type of insurance coverage as shown on the front of the card in "Ins." block.

Information to Recipients, including limitations, coverage and emergency care through the KenPAC system.

PROVIDERS OF SERVICE

This card certifies that the person listed hereon is eligible during the period indicated on the reverse side, for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.

NOTE: This person is a KenPAC recipient, and you should refer to section (1) and (2) under "Recipient of Services."

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to: Cabinet for Human Resources
Department for Medicaid Services
Frankfort, KY 40621

Insurance Identification

A—Part A, Medicare Only
B—Part B, Medicare Only
C—Both Parts A & B Medicare
D—Blue Cross /Blue Sheild
E—Blue Cross /Blue Shield Major Medical
F—Private Medical Insurance
G—Champus
H—Health Mainentance Organization
J —Other and / or Unknown
L —Absent Parent's Insurance
M—None
N—United Mine Workers
P—Black Lung

RECIPIENT OF SERVICES

1. The designated KenPAC primary provider must provide or authorize the following services: physician, hospital in-patient and out-patient, home heath agency, laboratory, ambulatory surgical center, primary care center, rural health center, and nurse anesthetist. Authorization by the primary provider is not required for services provided by ophthalmologists or board eligible or board certified psychiatrists , for obstetrical services provided by an obstetrician or gynecologist, or for other covered services not listed above.
2. In the event of an emergency, payment can be made to a participating medical provider rendering service to this person, if it is a covered service, without prior authorization of the primary provider shown on the reverse side.
3. Covered services which may be obtained without preauthorization from the KenPAC primary provider include services from pharmacies, community mental health centers, nursing homes, intermediate care facilities, mental hospitals, nurse midwives, and participating providers of dental, hearing, vision, ambulance, non-emergency transportation, screening, family planning services, and birthing centers.
4. Show this card to the person who provides these services to you whenever you receive medical care.
5. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below and destroy your old card. Remember that it is against the law for anyone to use this card except the person listed on the front of this card.
6. If you have questions, contact your eligibility worker at the county office.
7. Recipient (s) temporarily out of the state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services.

Signature

RECIPIENT OF SERVICES: You are hereby notified that under State Law KRS 205.624 your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Federal law provides for a $10,000 fine or imprisonment for a year, or both, for anyone who willfuly gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

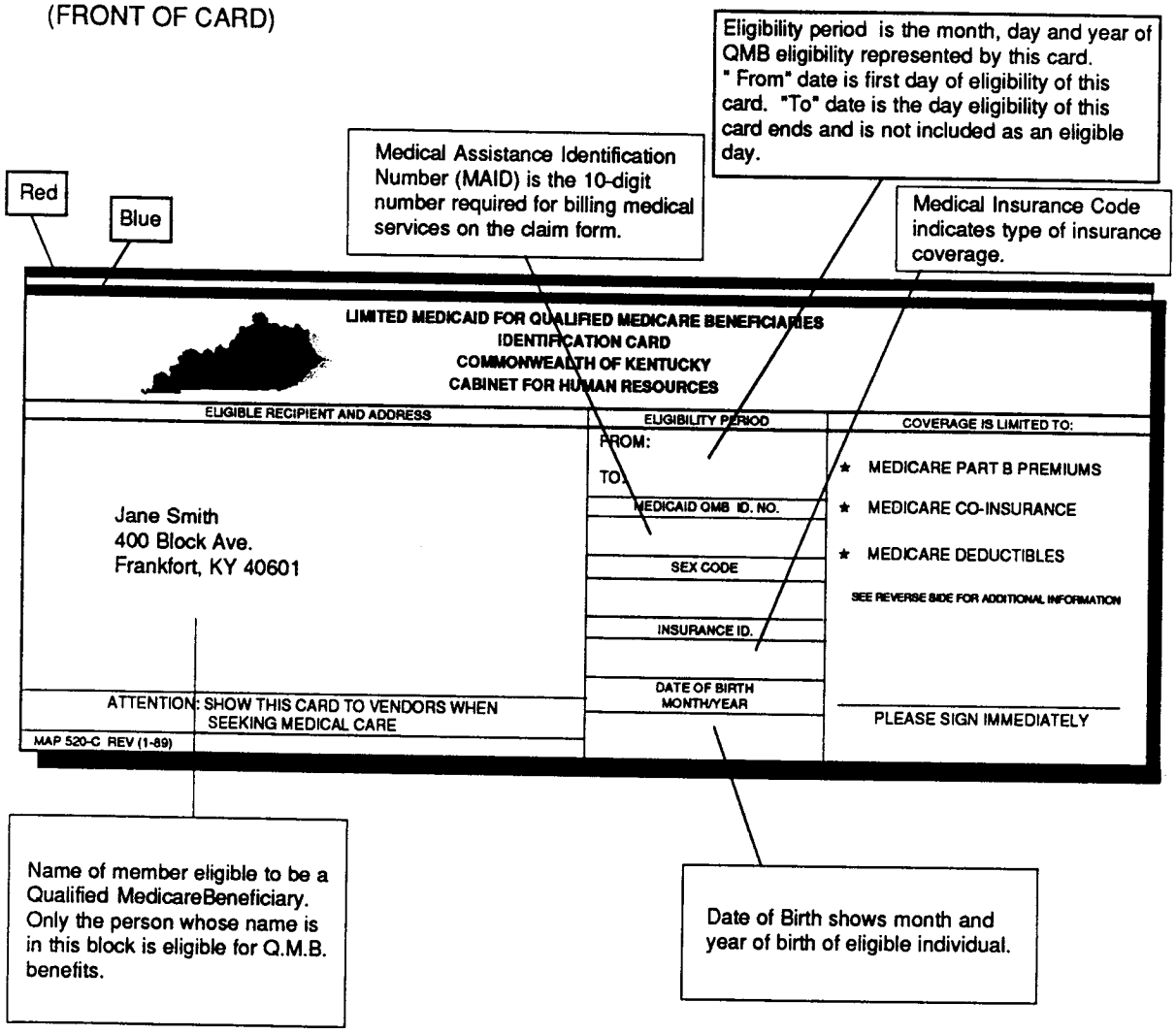
Recipient's signature is not required.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX II-D

QUALIFIED MEDICARE BENEFICIARY IDENTIFICATION (Q.M.B) CARD

(FRONT OF CARD)



QUALIFIED MEDICARE BENEFICIARY IDENTIFICATION (Q.M.B) CARD

(BACK OF CARD)

Information to Providers. including Insurance Identification codes which indicate type of insurance coverage as shown on the front of the card in "Ins." block.

Information to Recipients, including limitations, coverage and emergency care through QMB.

PROVIDERS OF SERVICE

1. The individual named on this card is a qualified Medicare beneficiary and is eligible for Medicaid payment for Medicare part A and Part B Co-insurance and Deductables only.
2. Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to:

   Cabinet for Human Resources
   Department for Medic..id Services
   275 East Main Street
   Frankfort, KY 40621-0001

Insurance Identification

A—Part A, Medicare Only
B—Part B, Medicare Only
C—Both Parts A & B Medicare
D—Blue Cross /Blue Sheild
E—Blue Cross /Blue Shield Major Medical
F—Private Medical Insurance
G—Champus
H—Health Mainentance Organization
J —Other and / or Unknown
L —Absent Parent's Insurance
M—None
N—United Mine Workers
P—Black Lung

RECIPIENT OF SERVICES

1. Show this card whenever you receive medical care.
2. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the front of the card immediately.
3. Remember that it is against the law for anyone to use this card except the person listed on the front of this card.
6. If you have questions, contact your case worker at the Department for Social Insurance County office.

RECIPIENT OF SERVICES: You are hereby notified that under State Law KRS 205.624 your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Federal law provides for a $10,000 fine or imprisonment for a year, or both, for anyone who willfuly gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D./Q.M.B.) CARD

(FRONT OF CARD)

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

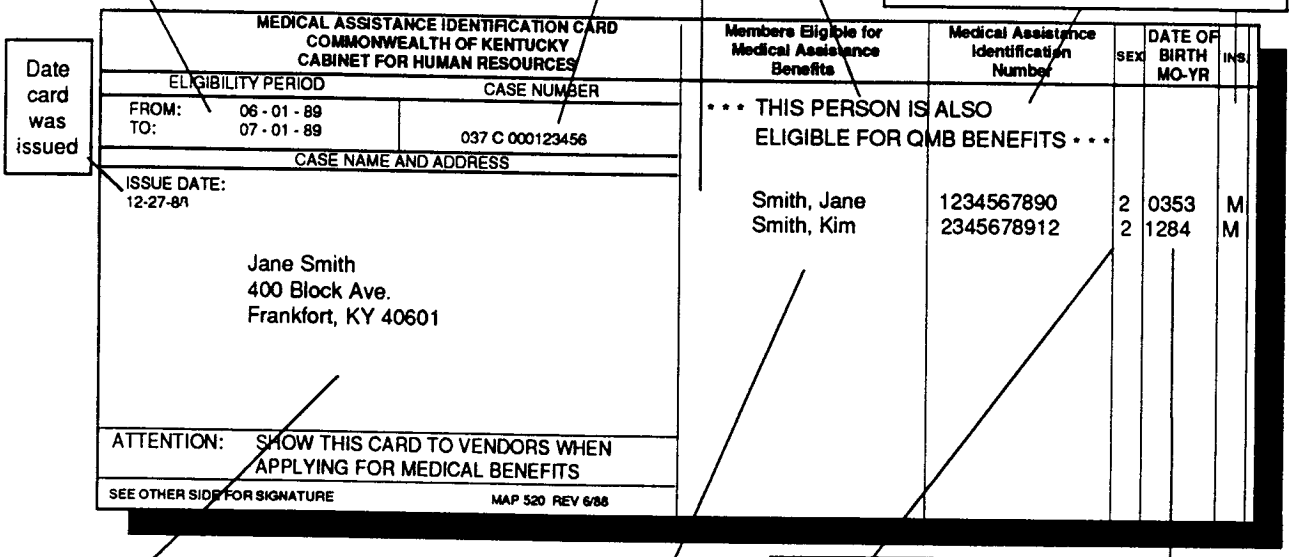
Medical Insurance Code indicates type of insurance coverage.

Eligibility period is the month, day and year of KMAP eligibility represented by this card. " From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

NOTICE QMB Infro.

Date card was issued



Case name and address show to whom the card is mailed. The name in this block may be that of a relative or other interested party and may not be an eligible member.

For K.M.A.P. Statistical Purposes

Date of Birth shows month and year of birth of each member . Refer to this block when providing services limited to age.

Name of members eligible for Medical Assistance benefits. Only those persons whose names are in this block are eligible for K.M.A.P. benefits.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX II-E

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D./Q.M.B.) CARD

(BACK OF CARD)

Information to Providers. Insurance Identification codes indicate type of insurance coverage as shown on the front of the card in "Ins." block.

This card certifies that the person(s) listed hereon is /are eligible during the period indicated on the reverse side for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to: Cabinet for Human Resources
Department for Social Insurance
Division of Medical Assistance
Frankfort, KY 40621

Insurance Identification

A Part A Medicare Only
B Part B Medicare Only
C Both Parts A & B Medicare
D Blue Cross Blue Shield
E Blue Cross Blue Shield Major Medical
F Private Medical Insurance
G Champus
H Health Mainentance Organization
J Other and or Unknown
L Absent Parent's Insurance
M None
N United Mine Workers
P Black Lung

RECIPIENT OF SERVICES

1. This card may be used to obtain certain services from participating hospitals, durg stores, physicians, dentists, nursing homes, intermediate care facilities. Independent laboratories, home health agencies, community mental health centers, and participating providers of hearing, vision, ambulance, non-emergency transportation, screening, and family planning services.
2. Show this card whenever you receive medical care or have prescriptions filled, to the person who provides these services to you.
3. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below, and destroy your old card. Remember that it is against the law for anyone to use this card except the persons listed on the front of this card.
4. If you have questions, contact your eligibility worker at the county office.
5. Recipient temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance.

Signature

RECIPIENT OF SERVICES: You are hereby notified that under State Law KRS 205 624 your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Federal law provides for a $10,000 fine or imprisonment for a year or both for anyone who willfully gives false information in applying for medical assistance fails to report changes relating to eligibility or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

New Form

Appendix VI
page 1

Election of Medicaid Hospice Benefit

I, _____ / _____, elect to receive the Medicaid
(Patient Name/ MAID#)

Hospice Benefit from _____ / _____ this _____ day of
(Facility Name) (Provider Number)

_____, 19 ____. I am aware that my disease is incurable. I consent to the management of the symptoms of my disease by _____. My family and I will help to develop a plan of care based on our needs. My care will be supervised by my attending physician, _____, and the Hospice Director. My outpatient medications will be provided by _____

I may receive benefits which include home nursing visits, counseling, medical social work services, medical supplies and equipment. If needed, I may also receive home health aides/homemakers, physical therapy, occupational therapy, speech/language pathology, in-patient care for acute symptoms, medical procedures ordered by my physician and hospice, and continuous nursing care in the home in acute medical crisis.

I may request volunteer services, when available.

I realize that my family and I have the opportunity for limited respite or relief care in a nursing facility.

In accepting these services, which are more comprehensive than regular Medicaid benefits, I waive my right to regular benefits except for payment to my attending physician, treatment for medical conditions unrelated to my terminal illness, medical transportation, nurse anesthetist, or dental.

I understand that I can revoke this benefit at any time and return to regular Medicaid benefits. I understand, if I terminate the Medicaid Hospice Benefit, I can resume regular Medicaid if I am still eligible.

I understand that the Hospice Benefit is a home care program. If my family and I choose care not available from the Hospice Agency, I understand that the Hospice and the Medicaid Program are not financially responsible.

I understand that the Hospice Benefit consists of three non-renewable benefits periods – two ninety-day periods, and one thirty-day period. I may be responsible for hospice charges if I exhaust my Medicaid Hospice Benefits, or if I become ineligible for Medicaid services.

I understand that at the end of either the first ninety-day period or the second, because of an improvement in my condition, I may choose to save the remainder of the benefit period(s). I may revoke the Hospice Benefit at that time.

I also understand that should I choose to do so, I am still eligible to receive the remaining benefit period(s); I am aware, however, that if I choose to revoke Hospice Benefits during a benefit period, I am not entitled to coverage for the remaining days of that benefit period.

I understand that if I choose to do so, once during each election period I may change the designation of the particular hospice from which hospice care will be received by filing a statement with the hospice from which care has been received and with the newly designated hospice. I understand that a change of hospice providers is not a revocation of the remainder of that election period.

I understand that, unless I revoke the Hospice Benefit, hospice coverage will continue for 210 consecutive days.

I understand that if I am a Medicare recipient, I must elect to use the Medicare Hospice Benefit.

Check one:

☐ I am a Medicare recipient and have elected to use the Medicare Hospice Benefit. My Medicare eligibility for hospice benefits begins _____.

☐ I am not a Medicare recipient.

☐ My Medicare Hospice Benefits have been exhausted as of _____.
(Date)

☐ I am currently a long term care facility resident, residing at:

_____
(Facility Name/Address)

Type of Facility: ☐ Skilled Nursing Facility ☐ Intermediate Care Facility

New Form

Hospice Benefit Election

Patient's Signature or Mark _____ Patient's Name (Print or Type) _____

Witness' Signature _____ Relationship to Patient _____

Date Signed _____ Effective Date of Election _____

.....

Second Certification Period: (To be signed only if benefits previously revoked or temporarily terminated)

Patient's Signature or Mark _____ Patient's Name (Print or Type) _____

Witness' Signature _____ Relationship to Patient _____

Date Signed _____ Effective Date of Second Period _____

.....

Third Certification Period: (To be signed only if benefit previously revoked or temporarily terminated)

Patient's Signature or Mark _____ Patient's Name (Print or Type) _____

Witness' Signature _____ Relationship to Patient _____

Date Signed _____ Effective Date of Third Period _____

Election of Medicaid Hospice Benefit

I, _____, elect to receive the Medicaid Hospice Benefit from _____ this _____ day of _____, 19___. I am aware that my disease is incurable. I consent to the management of the symptoms of my disease by _____. My family and I will help to develop a plan of care based on our needs. My care will be supervised by my attending physician, _____, and the Hospice Medical Director. My outpatient medications will be provided by _____.

I may receive benefits which include home nursing visits, counseling, medical social work services, medical supplies and equipment. If needed, I may also receive home health aides/homemakers, physical therapy, occupational therapy, speech/language pathology, in-patient care for acute symptoms, medical procedures ordered by my physician and hospice, and continuous nursing care in the home in acute medical crises.

I may request volunteer services, when available.

I realize that my family and I have the opportunity for limited respite or relief care in a nursing facility.

In accepting these services, which are more comprehensive than regular Medicaid benefits, I waive my right to regular benefits except for payment to my attending physician, treatment for medical conditions unrelated to my terminal illness, medical transportation, nurse anesthetist or dental.

I understand that I can revoke this benefit at any time and return to regular Medicaid benefits. I understand, if I terminate the Medicaid Hospice Benefit, I can resume regular Medicaid if I am still eligible.

I understand that the Hospice Benefit is a home care program. If my family and I choose care not available from the Hospice Agency, I understand that the Hospice and the Medicaid Program are not financially responsible.

I understand that the Hospice Benefit consists of three non-renewable benefit periods -- two ninety-day periods, and one thirty-day period. I may be responsible for hospice charges if I exhaust my Medicaid Hospice Benefits, or if I become ineligible for Medicaid services.

I understand that at the end of either the first ninety-day period or the second, because of an improvement in my condition, I may choose to save the remainder of the benefit period(s). I may revoke the Hospice Benefit at that time.

I also understand that should I choose to do so, I am still eligible to receive the remaining benefit period(s); I am aware, however, that if I choose to revoke Hospice Benefits during a benefit period, I am not entitled to coverage for the remaining days of that benefit period.

I understand that if I choose to do so, once during each election period I may change the designation of the particular hospice from which hospice care will be received by filing a statement with the hospice from which care has been received and with the newly designated hospice. I understand that a change of hospice providers is not a revocation of the remainder of that election period.

I understand that, unless I revoke the Hospice Benefit, hospice coverage will continue for 210 consecutive days.

I understand that if I am a Medicare recipient, I must elect to use the Medicare Hospice Benefit.

Check one:

☐ I am a Medicare recipient and have elected to use the Medicare Hospice Benefit. My Medicare eligibility for hospice benefits begins _____.

☐ I am not a Medicare recipient.

HOSPICE BENEFIT ELECTION

Patient's Signature or Mark

Patient's Name (Print or Type)

Witness' Signature

Relationship to Patient

Date Signed

Effective Date of Election

SECOND CERTIFICATION PERIOD: (To be signed only if benefit previously revoked)

Patient's Signature or Mark

Patient's Name (Print or Type)

Witness' Signature

Relationship to Patient

Date Signed

Effective Date of Second Period

THIRD CERTIFICATION PERIOD: (To be signed only if benefit previously revoked)

Patient's Signature or Mark

Patient's Name (Print or Type)

Witness' Signature

Relationship to Patient

Date Signed

Effective Date of Third Period

MAP-375 (8/88) New Form

Revocation of Medicaid Hospice Benefits

I, _____/_____ revoke the hospice benefit allowed
(Patient Name/MAID #)

to me by Medicaid and rendered by _____
(Hospice Agency)

_____ this _____ day of _____, 19____.
(Provider #)

I understand that any remaining days of this election period will not be available to me.

I understand that I may elect hospice care at a later time if this revocation has occurred during either of the two initial 90-day benefit periods.

I understand that as of the date of this revocation, if I am still eligible, my regular Medicaid benefits will be restored.

_____ _____
Patient's Signature Witness' Signature

_____ _____
Date Date

FOR OFFICE USE ONLY

Rationale of Revocation: _____

_____

_____

_____

_____

_____

_____

[MAP-3/9]

APPENDIX VII

Revocation of Medicaid Hospice Benefits

I, _____ revoke the hospice benefit allowed to me by Medicaid and rendered by _____ this _____ day of _____, 19___.

I understand that any remaining days of this election period will not be available to me.

I understand that I may elect hospice care at a later time if this revocation has occurred during either of the two initial 90-day benefit periods.

I understand that as of the date of this revocation, if I am still eligibl my regular Medicaid benefits will be restored.

_____ Patient's Signature

_____ Witness' Signature

_____ Date

_____ Date

FOR OFFICE USE ONLY

Rationale of Revocation: _____

MAP-376 (8/88) New Form

Change of Hospice Providers

I _____ wish to change the designation of
(Patient Name/MAID #)
the particular hospice from which I receive hospice care. I no longer wish to receive hospice service from _____, but
(Provider Name/Number)
instead wish to receive hospice care from _____,
(Provider Name/Number)
effective this _____ day of _____, 19_____.

I understand that this change of hospice providers is not a revocation of the remainder of this election period.

_____ _____
Patient's Signature or Mark Witness' Signature

_____ _____
Date Date

MAP-403 (8/88) New Form APPENDIX IX

Hospice Patient Status Change

The status of _____ / _____ who has been
Patient Name MAID #

receiving hospice benefits from _____
Hospice Agency

_____ since _____ has changed as indicated below.
Provider # Date of Election

As of _____
Date

/_/ Patient's Medicare benefits have been exhausted.

/_/ Patient has become eligible for Medicare benefits.

/_/ Patient is a resident at _____ which is
Name of Facility

a /_/ skilled nursing /_/ intermediate care facility.

/_/ Patient has changed levels of care. Patient has transferred from

_____ which is a /_/ skilled nursing
Name of Facility

/_/ intermediate care facility to _____
Name of Facility

which is a/_/ skilled nursing /_/ intermediate care facility.

/_/ Patient has returned to a home setting and is no longer a resident at

_____
Name of Facility

/_/ Patient is in long term/inactive status due to improvement in condition.

_____ will continue to
Hospice Agency

follow patient, but active hospice benefits are temporarily discontinued. Patient may return to active status at any time a change in condition necessitates with no loss of remaining benefit period(s). Patient has used _____ days of 210-day benefit period.

/_/ Patient elects to return to active status after having been in inactive status since _____. Patient has _____ days remaining in 210-day benefit
Date

period.

/_/ OTHER (Please describe any other change in patient status.)

_____

_____

_____ _____
Patient Signature Hospice Agency Representative Signature

[MAP-377]

APPENDIX IX

Request for Extension of
Medicaid Hospice Benefits

I, _____ request that my Medicaid Hospice Benefits received from _____ be extended for an additional 60 days, beginning the _____ day of _____, 19___. I understand that during this 60-day extension period I waive my right to regular Medicaid benefits except for payment to my attending physician or treatment for medical conditions unrelated to my terminal illness.

I understand that after _____, 19___, no additional hospice benefits will be provided.

_____
Patient's Signature

_____
Witness' Signature

_____
Date

_____
Date

New Form

MAP-378 (8/88)

Termination of Medicaid Hospice Benefits

Hospice benefits for _____/_____ are hereby
(Patient Name/MAID #)
terminated effective _____, 19___, for the following reason.

/_/ Patient is deceased. Date of death is _____, 19_____.

/_/ Patient has not requested extension of Medicaid hospice benefits.

/_/ Patient has used maximum lifetime hospice benefit days.

/_/ OTHER (Please clarify) _____

_____

_____

_____

/_/ Condition improved. Patient in Long Term/Inactive Status.

_____
(Hospice Agency) (Provider #)

will continue to follow patient but active hospice benefits are temporarily discontinued. Patient may return to active status any time change in condition necessitates with no loss of remaining benefit periods.

_____/_____
Hospice Agency Provider #

_____
Hospice Medical Director

_____
Date

[MAP-378]

APPENDIX X

TERMINATION OF MEDICAID HOSPICE BENEFITS

Hospice benefits for _____
are hereby terminated effective _____, 19 _____,
for the following reason.

/_/ Patient is deceased. Date of death is _____, 19 _____.

/_/ Patient has not requested extension of Medicaid hospice benefits.

/_/ Patient has used maximum lifetime hospice benefit days.

/_/ OTHER (Please Clarify) _____

_____

_____

_____

_____

_____
Hospice Agency

_____
Hospice Medical Director

_____
Date

MAP-552
(R. 4/88)

New Form

COMMONWEALTH OF KENTUCKY
Cabinet for Human Resources
Department for Social Insurance

NOTICE OF AVAILABILITY OF INCOME
FOR LONG TERM CARE/WAIVER
AGENCY/HOSPICE

APPENDIX XVI

A.
Case Name _____
[ ] Committee [ ] Payee
Case No. _____

B. [ ]Initial [ ]Change

C. Client's Name _____ Birth Date _____ (Mo./Yr.) [ ]Title XVIII [ ]Title

D. Current Facility/
Waiver Agency/Hospice _____ Address _____

Actual Admission Date to
this Facility/Waiver Agency/Hospice _____

Date of Discharge or
Date of Death (If Applicable) _____

[ ]SNF [ ]ICF [ ]ICF
[ ]MH/PSY [ ]HCBS
[ ] AIS/MR [ ]Hospice

E. Previous Facility/
Waiver Agency/Hospice _____ Address _____

Admission Date _____ Date of Discharge _____ Type: [ ]SNF [ ]ICF [ ]ICF/MR [ ]MH/PSY [ ]FCH
[ ]PCH [ ]HCBS [ ]AIS/MR [ ]Hospice

F. Family Status

1. [ ]Single [ ]Married No. of Children _____

Total Dependents _____

2. Spouse
[ ]Ineligible [ ]Eligible [ ]Patient [ ]Non-Patient

(Co.) (Prg.) (Number)

G. Income Computation

1. Unearned Income

Source of Unearned Income	Amount
a. RSDI (Including SMI if dedct. by SSA)	
b. SSI	
c. RR (Including SMI, if dedct. by RR)	
d. VA	
e. State Supplementation	
f. Other (Specify) _____	
g. Sub-Total Unearned Inc. (1a thru 1f)	$

2. Earned Income

	Amount
a. Income _____ (Source)	
b. Earned Income Deduction(s)	-
c. Sub-Total Earned (2a-2b)	$

3. Total Income (1g plus 2c) $

4. Deductions

	Amount
a. Incurred Medical Expenses (Exclude Health Ins. of Client)	
b. Health Insurance 1) SMI (JKM Only)	
2) Other Health Ins.	
c. Spouse/Family Maintenance	
d. Personal Needs Allowance	$
e. Total Deductions (4a thru 4d)	$

5. Available Income (3 minus 4e) $

6. Available Income (rounded) $

H. Explain Incurred Medical Expenses

List full names and policy numbers of all health insurance policies.

I. Status

1. Active Case [ ]Yes [ ]No
2. If active, Eff. Date for MA _____
3. If discontinued, Eff. Date of MA Disc. _____
4. Program Code Change [ ]Yes [ ]No
From _____ To _____ Eff. _____
5. SSI Entitlement Confirmed
Confirmation Date _____
6. Available Monthly Income (Item G-6) _____
Effective Date (Change forms only) _____

J. Comment Section

1. [ ]LO1 [ ]MAP-24 [ ]MAP-374
[ ]DMS Letter of Approval
[ ]DMR-001. . . . . _____ (Date Received)

2. Corrected MAP-552
Correction of MAP-552 dated _____

3. [ ]Private Pay Patient
From _____ to _____

4. [ ]PAFS-105. . . Date Sent _____

5. Additional comments:

K.

(Signature) (Date)

New Form

APPENDIX XVII

MAP-383 (11/88)

Other Hospitalization Statement

This is to certify that hospitalization at

_____
Name of Facility

for _____ beginning on
Recipient Name/MAID Number

_____ is not related to the terminal illness of this
Date of Admission

patient.

The reason for this admission is _____/_____
Diagnosis ICD 9 CM Code

This patient's terminal illness is _____/_____
Diagnosis ICD 9 CM Code

Charges for this hospital stay should not be billed to the hospice agency but should be billed directly to the Kentucky Medical Assistance Program.

Signed: _____
Medical Director

_____
Hospice Agency

_____
Date

Please attach documentation verifying that hospitalization is not related to terminal illness.

Is this the first time this patient has been hospitalized for a condition not related to the terminal illness? /_/ Yes /_/ No

If no, dates of previous admission _____

Diagnosis for previous admission _____
ICD 9 CM Code

/_/ Approved by the KMAP /_/ Denied by the KMAP

_____
KMAP Signature Date

[MAP-383 (03/87)]

OTHER HOSPITALIZATION STATEMENT

This is to certify that hospitalization at

_____
Name of Facility

for _____ beginning on
Recipient Name/MAID Number

_____ is not related to the terminal illness of
Date of Admission

this patient. Charges for this hospital stay should not be billed to the hospice agency but should be billed directly to the Kentucky Medical Assistance Program.

Signed: _____
Medical Director

_____
Hospice Agency

_____
Date

New Form

MAP-384 (8/88)

HOSPICE DRUG FORM

1. Recipient Last Name	2. First Name	3. Medical Assistance I.D. No.

4. Date Medicaid Hospice Coverage Began	5. (1) First Diagnosis (Not Related to Terminal Illness)	ICD.9 CM Code
6. Total Number of Prescriptions Not Related to Terminal Illness	(2) Second Diagnosis (Not Related to Terminal Illness)	ICD.9 CM Code

7. Drug Name Manufacturer/Strength (10 mg, 15 ml, etc.)	8. NDC #	9. Units	10. Price Per Unit	11. Total Charge	12. Medicaid Maximum Allowance (Leave Blank)
		13. Total Units This Invoice		14. Total Charge This Invoice	

15. Terminal Diagnosis	ICD. 9 CM Code	16. Did Patient Require These Prescriptions Prior to Diagnosis or Terminal Illness?
		___ YES ___ NO

17. Are These Prescriptions the Result of Hospitalization not Related to Terminal Illness?

___ YES ___ NO

18. If yes, Dates of Hospitalization:

FROM _____ TO _____

19. Name of Hospital	20. Prescribing Physician

21. PROVIDER CERTIFICATION AND SIGNATURE: This is to certify that the prescriptions entered above are not related to the terminal illness of this recipient.

Signed _____

22. PROVIDER NAME AND ADDRESS	23. PROVIDER NUMBER	24. INVOICE DATE	25. INVOICE NUMBE

[MAP-384 (03/87)]

HOSPICE DRUG FORM

1. Recipient Last Name	2. First Name	3. Medical Assistance I.D. No.

4. Date Medicaid Hospice Coverage Began	5. (1) First Diagnosis (Not Related to Terminal Illness)	ICD.9 CM Code
6. Total Number of Prescriptions Not Related to Terminal Illness	(2) Second Diagnosis (Not Related to Terminal Illness)	ICD.9 CM Code

7. Drug Name	8. NDC #	9. Units	10. Price Per Unit	11. Total Charge	12. Medicaid Maximum Allowance (Leave Blank)
		13. Total Units This Invoice		14. Total Charge This Invoice	

15. PROVIDER CERTIFICATION AND SIGNATURE: This is to certify that the prescriptions entered above are not related to the terminal illness of this recipient.

Signed

16. PROVIDER NAME AND ADDRESS	17. PROVIDER NUMBER	18. INVOICE DATE	19. INVOICE NUMBER

MAP-397 (8/88)

New Form

Other Services Statement

APPENDIX XIX

This is to certify that the service(s) checked below provided by

_____
Name of Agency

for _____ beginning on
Recipient Name/MAID Number

_____ is/are not related in any way to the terminal illness
Date
of this patient.

The reason for the service(s) is _____ / _____
Diagnosis ICD 9 CM Code

The patient's terminal illness is _____ / _____
Diagnosis ICD 9 CM Code

Charges for this/these service(s) should not be billed to the hospice agency but should be billed directly to the Kentucky Medical Assistance Program.

Signed: _____
Medical Director

_____
Hospice Agency

_____
Date

/_/ Durable Medical Equipment (List) _____

/_/ Hospital Outpatient Services (Please Describe Service/Reason) _____

Please attach documentation indicating service(s) is/are not related to terminal illness.

Is this the first time this patient has required services not related to terminal illness? /_/ Yes /_/ No

If no, date(s) of previous service _____.

Previous diagnosis not related to terminal illness for which services were required

_____
ICD 9 CM Code

/_/ Approved by the KMAP /_/ Denied by the KMAP

_____ _____
KMAP Signature Date

[MAP-397 (7/87)]

APPENDIX XIX

OTHER SERVICES STATEMENT

This is to certify that the service(s) checked below provided by

_____
Name of Agency

to _____
Recipient Name/MAID Number

on _____ is/are not related in any way to the terminal illness of
Date

this patient. Charges for this/these service(s) should not be billed to the hospice agency but should be billed directly to the Kentucky Medical Assistance Program.

Signed: _____
Medical Director

_____
Hospice Agency

_____
Date

/_/ Durable Medical Equipment (List) _____

_____

_____

_____

/_/ Hospital Outpatient Services (Please Describe Service/Reason) _____

_____

_____

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Please attach documentation indicating service(s) not related to terminal illness.

Approved by the KMAP /_/ Denied by the KMAP /_/